

## Social responsibility is theme of health educators' annual meeting

By Jim Garner

According to some warm-hearted believers, there is such a thing as a mystic god of social relevance; if this were really so one could imagine the arrangements committee for last month's Calgary medical education jamboree stretched out on their prayer mats each morning, doing obeisance in the appropriate direction.

However it came about, a couple of hundred delegates representing, one hopes, the cream of Canadian health science academia came together to consider the world energy situation and the need for Canadian government policies of energy-demand-shaping. Rather a long way from the cutting and stitching of human flesh, or even the respective merits of rectal and oral thermometers, but it was all part of the lead-in

toward a debate on humanizing the health sciences.

The meeting was of the national associations of Canadian medical colleges, Canadian teaching hospitals, deans of pharmacy of Canada, university schools of nursing and university schools of rehabilitation.

The program moved from the above-mentioned speech on world energy by a UBC professor of zoology, Dr. Ian Efford, through a presentation by designer Peter Mill on how buildings (specifically medical buildings but no less applicable to any other kind of people-container) could use less energy, and on to a talk by Associate Dean Dr. A. D. Dickson of the University of Calgary medical faculty entitled "The dilemmas of alternatives".

Dr. Dickson, taking energy as his theme, parlayed this into a plea that humane professions should be concerned with the plights of all peoples and other species.

### Puzzlement

To date the connections of all this were distinctly tenuous, how tenuous being indicated by the puzzlement evident in the coffee-break gossip. The general assumption seemed to be that Calgarians are oil-conscious and that the program was planned at a time when even mere Easterners were being forced to think of the subject. The development of the theme, it was charitably assumed, would appear like a who-dunit denouement in the final stages.

Sure enough, the meat of the meeting came in the last morning, when Dr. C. A. Hooker, a professor of philosophy and environmental engineering from the University of Western Ontario, discussed systems analysis. He was followed by Dr. Josephine Flaherty, dean of nursing at the same locale, and Dr. Kenneth Marshall, associate dean of medicine at McGill, discussing social responsibility and the education of health professionals.

All three succeeded in getting the word energy into their speeches as often as they remembered to, but their presentations would have been equally acceptable after a lead-in based on the supply-demand pattern of nylon stockings. In short, the tactics failed but the strategy succeeded.

Dr. Marshall told the delegates that the socially responsible physician is warm, compassionate, sensible and appreciative of his coworkers — qualities killed, he said, by the first two years of medical school. "To survive you have to sell your soul," he declared, "and those who emerge have slots for



Marguerite Schumacher, centre, director of Calgary University school of nursing, discusses curricula with speakers Dr. Kenneth Marshall, McGill, and Dr. Josephine Flaherty, Western.

everything; they are clever, competent and cold."

But brain-washing doesn't always work — which, Marshall declared, is why the sick person can still find an empathetic physician.

#### Correct attitude

You do not create the socially responsible physician by curricular change; nevertheless he proposed some course changes to encourage attitudes that Dr. Marshall regarded as more acceptable. Notably a minor shift from science to humanities, and a special "school within a school" where a small cadre of medical students would spend extra time learning the anatomy of society as well as that of the human body.

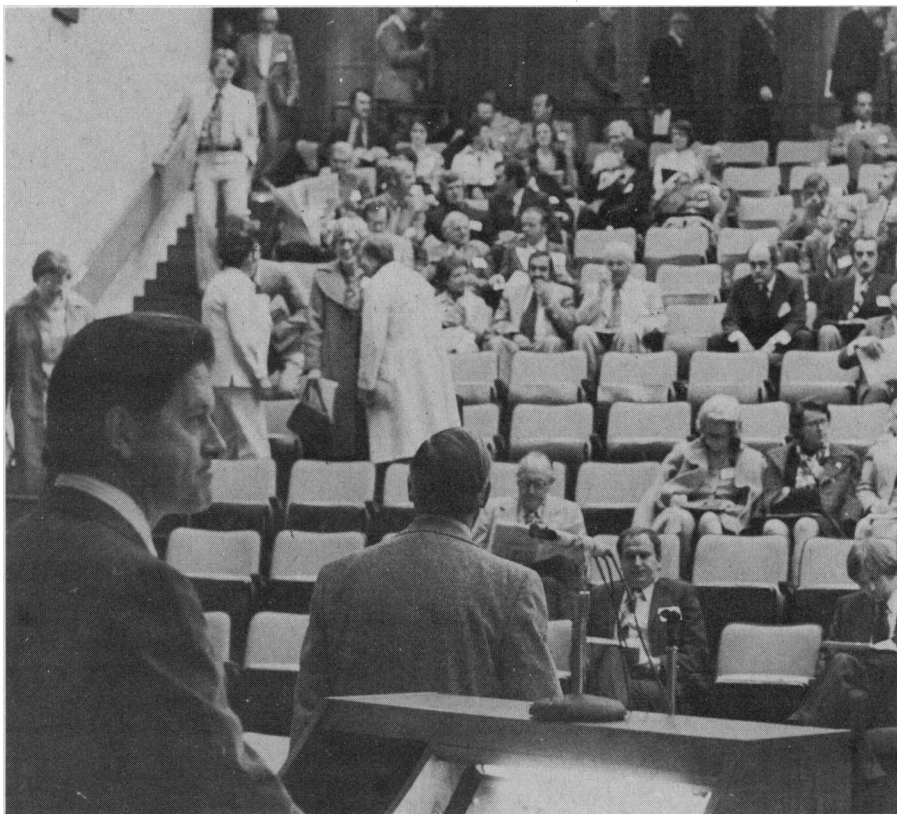
He saw this school as offering a course two years longer than the standard one. The pressure of two years' concentrated study of biological science would be eased and the students would spend time at the bottom of the hierarchy — cleaning hospitals, servicing drop-in centres and what-have-you. The students would mingle with other parts of the medical school and be subject to the same exam requirements.

#### General improvements

Shifts in the general curriculum would include a minor cut in basic biological science and more unscheduled time, an upgrading of behavioural courses (such as using live patients), short optional courses in behavioural or related subjects, a course in medical ethics (including ecological issues), more small-group teaching, more electives in the clinical year and clinical rotations in primary care facilities in which other health professionals have equality of status.

This approach, Dr. Marshall suggested, would produce a nucleus of socially responsible physicians; the changes would spread until the evolutionary process produced a socially responsible medical profession.

Dr. Hooker, by training a nuclear physicist and philosopher, analysed modern institutions and concluded that most of them, notably hospitals, are



Dr. L. E. McLeod, dean of medicine at Calgary, chaired session

not capable of changing to meet the needs of society. Most, he said, are "commodity intervention institutions" designed to do one thing well but not to relate it to need. Thus a hospital emergency department patches up broken bodies very well, but it does not inquire into the redesign of the transport system to render this patching unnecessary.

"Health care," he defined, "is a commodity offered in a market and bought by individual clients according to self-defined needs." The pattern of health care is a function of industrial and social design.

#### Our century

For the very first time, Dr. Hooker said, we have begun to be conscious of the need to choose our own design. This should be the century of transition to

the first animal society that did so.

During the three-day meeting the Association of Canadian Medical Colleges also held a scientific meeting. Sixteen papers were listed, the subjects ranging from sex education in medical schools to the need for new administrative tools to cope with the demand by government for more stringent budgeting procedures. But most of the papers concerned students — how to evaluate them, how to teach them or how to provide them with guidance.

Dr. Arnold Naimark of Winnipeg was elected president of the ACMC, succeeding Dr. Pierre Bois, Montreal. Vice-president is Dr. Douglas Waugh, Kingston, and hon. treasurer is Dr. J. F. Mustard, Hamilton. Members-at-large of the executive are Drs. D. V. Bates, Vancouver, and Gilles Pigeon, Sherbrooke. ■

Most of the money spent heating a hospital or other building is wasted, it would seem from a talk to the joint annual meeting by Peter Mill, a professor of environmental design at University of Calgary. He said there is one building in Toronto which uses no energy at all for heating until the outside temperature gets to five below.

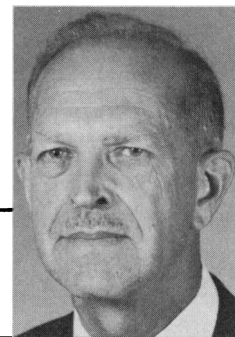
Even the Eskimo igloo is a more heat-efficient building than most of our hospitals, he told the meeting.

The biggest single saving can come from proper balancing of the heating-lighting-cooling systems. Mostly they are all fighting each other. Heat recycling would make it possible for the lighting and refrigeration energy to provide most of the needed heat.

Mr. Mill said levels of many lighting and ventilation

systems are far higher than the optimum. Another wasteful practice is having buildings in use for eight hours a day heated and lighted to the same level day and night. Lowering the thermostat five degrees overnight would, he calculated, produce fuel savings of 3% in Calgary and 7% in Vancouver.

Buildings, especially hospitals, are often designed for lowest capital costs but higher running costs because of budgetary pressures (or taxation in the case of commercial buildings). Hospitals have so much window space as to create unwanted glare, at the same time losing heat. L-shaped buildings are heat-wasteful, and toilets and corridors could well be located next to outside northern walls and heated at a lower level. Poor insulation and sealing and aluminum windowframes also contribute to heat loss, he said. Outside shades reduce the energy requirements for cooling.



## Medical Council of Canada. Part VIII: how council completes medical circuit

"From what you have said about the Medical Council of Canada," said the Newcomer, "it has a variety of tasks, all of which appear to me to be jolly difficult. It has to establish and continually review the level of its qualification through the type and complexity of its examinations; it provides, as a spin-off, a means of external assessment of the medical educational process in Canadian universities; it has to maintain the Canadian Medical Register. To accomplish these tasks, you must surely be closely associated with the universities and with the provincial licensing authorities and dear knows who else. You have told me about your dealings with applicants for examination and registration, which are personal and direct. In connection with these other responsibilities, hopefully you follow John Donne's dictum that 'No man is an island'. I throw that in to show my erudition. With whom or what and how do you maintain the rest of your liaison?"

"We deal with scads of people, authorities and associations," They said, "including those of government, licensing authorities and educational institutions. We keep in constant liaison with them both internally within the council and externally. On the internal aspect first: you will remember that the members of council are appointed by government, elected by the provincial medical councils and named by the universities. This representation enables a constant flow of opinion, advice and information to pass between the council and the authorities concerned with the provision of health care, with medical education and its assessment and with licensing matters. Under the general heading of internal association would come the normal administrative dealings which we have, as you would suspect, with legal counsel, bankers and auditors.

"Our external associations are equally important and, you will find, almost as productive as the internal ones. On the government aspect, we deal with the Department of National Health and Welfare (not with agriculture, where we

were assigned originally, nor with the secretary of state where we were for a time, for some unknown reason), and within that department, mainly with the health program's branch. On the medical education side, we deal with medical faculties directly on some subjects, but on broad policy matters and, frequently, to pick their brains; we have a lot of dealings with the Association of Canadian Medical Colleges. For the same reasons, our close association with the Royal College of Physicians and Surgeons of Canada is equally valuable. In addition, we have dealings with specialty associations and societies and with the College of Family Practice of Canada. Liaison with all these authorities is most helpful to us.

"Equally helpful for individual problems in licensing and registration are our constant dealings with the registrars of the provinces. On matters dealing with more than one province, our associate membership in the Federation of Provincial Medical Licensing Authorities is most valuable. The Canadian Medical Association, particularly its Council on Medical Education, is always ready to lend pertinent and timely assistance in many matters.

### Hardly reticent

"Helpful as all these people, departments and associations are, they have their own opinions on how well we do our job and they are not reluctant to express themselves. You may find, from time to time, that we are in the 'beaten zone' of their missiles, as your machine-gunner friends would say. Still, their comments are always constructive."

"Fair enough," said the Newcomer, "but you seem to have scampered past the National Board of Medical Examiners and the R. S. McLaughlin Examination and Research Centre. You talked about them in our previous sessions and now you leave them out. Is this an oversight, or what?"

"Not so," They said, "we are coming to them. The National Board of Medi-

cal Examiners produces the test papers made up of the items which our test committees select; it machine-marks the efforts of the candidates on our test papers; it provides us with printouts of results and with statistics; it invites our representatives to its meetings; and it provides us with advice on procedure. And it sends us bills. We have lots of contact with the board, helpful and productive contact.

"The R. S. McLaughlin Examination and Research Centre stands in somewhat the same relationship with us as does the national board. Since the centre is an instrument, in the legal phrase, of the Royal College of Physicians and Surgeons of Canada, we do some of our dealings with the centre through the Royal College. But because Dr. D. R. Wilson, the director of the centre, is our consultant on examinations, we naturally deal with him a lot personally. And as we progress with our project of transferring the conduct of our examinations from the national board to the centre, a project we started a year or so ago, we will have progressively more liaison with the centre itself and a decreasing liaison with the national board. Hopefully, this latter liaison will never cease entirely, however. But you can expect to see a greater and greater degree of involvement between ourselves and the McLaughlin centre in the next few years at the level of test committees with Dr. Wilson and with its advisory board which is chaired, as you may know, by Dr. R. C. Dickson of Halifax.

"So there you are, Newcomer," They said, "that is the array of the major associations which we maintain. There are others, local and international, but these are the groups we most frequently consult in connection with the assessment of medical education and with licensure. You will agree, now, that the council is, to continue with your quotation from John Donne, 'a piece of the continent, a part of the main'. But surely you knew that before, from what we have already told you about the Medical Council of Canada."■

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## Canadian Psychiatric Association registration exceeds 900 at Ottawa annual meeting

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By S.T. Firth, M.D.

Not even an early-morning fire and evacuation of the Chateau Laurier Hotel could discourage the more than 900 registrants to the 24th annual meeting of the Canadian Psychiatric Association held this year in Ottawa and presided over by Dr. Rhodes Chalke.

As usual, the 130-or-so papers and symposia dealt with a wide variety of subjects, ranging from the politics of community psychiatry to amphetamine studies in the mouse. But it was probably the opening remarks of Jeanne Sauve, Canada's environment minister, that set an atmosphere of seriousness, if not urgency at times. She reminded members that the final common pathway of social action is obviously the human mind and that the solutions to looming environmental crisis lie in the understanding of human motivation. Governments need, therefore, the advice of professionals in the field of human behaviour, but advice that is based on sound data and not on outcome of the "garbage in, garbage out" process.

Frank S. Miller, Ontario minister of health, made a similar plea for partnership in combating "diseases of choice", namely "the consequences of the abusive use of alcohol, drugs and tobacco... unwise and immoderate eating... failure to take reasonable exercise... incautious sex... reckless driving... even reckless walking... and dangerous work habits". He also urged the Canadian Psychiatric Association to make a "determined and concerted effort to come to grips with the problems of chronic mental disorder" and had some specific requests in that area.

### Smoking and hyperkinesia

Dr. Raymond Denson, Saskatoon, has been concerned with one possible "disease of choice", namely, hyperkinesia in children of smoking mothers. He found that mothers of methylphenidate-sensitive, hyperkinetic children have a mean cigarette consumption significant-



Normalcy may depend on pregnant woman's decision to smoke

ly greater than that of the mothers of dyslexic children and normal controls. No such difference was demonstrated in the fathers of the three groups. Denson postulates that the child of the mother who smokes heavily may suffer from anoxia during delivery. This was of particular significance in view of the warning of Dr. A. S. Davidson, Toronto, that recent follow-up studies and his own clinical experience suggest that adult sequelae of minimal brain dysfunction in children tend to be underdiagnosed.

Two papers from the Allan Memorial Institute laboratories of Dongier and Dubrovsky described EEG findings which suggest some diagnosis specificity which might prove to be of both practical and theoretical value. When cere-

bral electrical activity on the frequency range of EEG is filtered out, slow potentials can be recorded using long-time constant and averager or computer. When the patient is given a warning stimulus and an imperative stimulus which he is requested to arrest by pressing a button, an expectancy wave or contingent negative variation is recorded. In normal subjects, there is usually a return to baseline after the subject has obeyed the orders but in a majority of psychotic patients there is an apparent prolongation of the CNV, a phenomenon described by Dongier in 1969 and termed postimperative negative variation (PINV).

In an inpatient group of 146 schizophrenics, prolonged PINV was found in 75% as compared with 37% of a

# MAXERAN<sup>®</sup>

The modifier of digestive behaviour

**Classification:** MAXERAN<sup>®</sup> (metoclopramide monohydrochloride) is a modifier of upper gastrointestinal tract motility.

**Indications:** *Sub-acute gastritis, chronic gastritis, gastric sequelae of surgical procedures such as vagotomy and pyloroplasty.*

Under these conditions, when gastric emptying is delayed, Maxeran may relieve such symptoms as nausea, vomiting, epigastric distress, bloating, etc.

**Small bowel intubation:** Maxeran may facilitate and accelerate small bowel intubation.

**Side-effects:** Drowsiness and, more rarely, insomnia, fatigue, headaches, dizziness and bowel disturbances have been reported. Parkinsonism and other extrapyramidal syndromes have been reported infrequently. An increase in the frequency and severity of seizures has been reported in conjunction with the administration of Maxeran to epileptic patients.

**Precautions:** Drugs with atropine-like action should not be used simultaneously with Maxeran since they have a tendency to antagonize effect of this drug on gastrointestinal motility. Maxeran should not be used in conjunction with potent ganglioplegic or neuroleptic drugs since potentiation of effects might occur.

Maxeran should not be used in patients with epilepsy and extrapyramidal syndromes, unless its expected benefits outweigh the risk of aggravating these symptoms.

In view of the risk of extrapyramidal manifestations, metoclopramide should not be used in children unless a clear indication has been established.

The recommended dosage of Maxeran should not be exceeded since a further increase in dosage will not produce a corresponding increase in the clinical response. The dosage recommended for children should not be exceeded.

**Contraindications:** Maxeran should not be administered to patients in combination with MAO inhibitors, tricyclic antidepressants, sympathomimetics and foods with high tyramine content, since safety of such an association has not yet been established. As a safety measure, a two-week period should elapse between using Maxeran and administration of any of these drugs.

The safety of use of Maxeran in pregnancy has not been established. Therefore Maxeran should not be used in pregnant women, unless in the opinion of the physician the expected benefits to the patient outweigh the potential risks to the fetus.

## Dosage and administration:

### For delayed gastric emptying

#### Adults

**Tablets:** ½ to 1 tablet (5 — 10 mg) three or four times a day before meals.

**Liquid:** 5 — 10 ml (5 — 10 mg) three or four times a day before meals.

**Injectable:** When parenteral administration is required, 1 ampoule (10 mg) I.M. or I.V. (slowly) to be repeated 2 or 3 times a day if necessary.

**Children:** (5 to 14 years):  
**Liquid:** 2.5 to 5 ml (2.5 — 5 mg)

### For small bowel intubation:

**Adults:** One ampoule (10 mg) I.V. — 15 minutes before intubation. Other routes (oral or I.M.) may be used but with a greater period of latency.

**Children:** (5 to 14 years):  
2.5 to 5 ml (2.5 — 5 mg)

### Availability:

**Tablets:** Each white scored compressed tablet contains 10 mg of Metoclopramide Monohydrochloride. Bottles of 50 & 500 tablets.

**Liquid:** Each ml contains 1 mg of Metoclopramide Monohydrochloride. Available in bottles of 110 ml and 450 ml.

**Injectable:** Each 2 ml ampoule contains 10 mg of Metoclopramide Monohydrochloride in a clear colourless solution. Keep away from light and heat. Available in boxes of 5 and 50 ampoules.

Product monograph available upon request.



**Jeanne Sauvé:**  
mind is final path to action

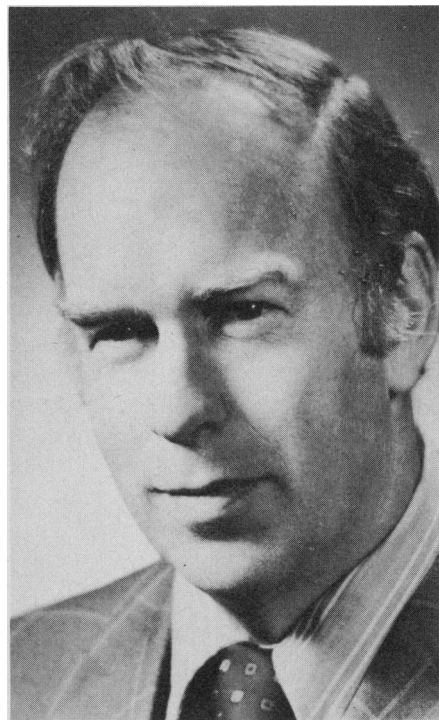
group of neurotic patients and 16% of a normal group. If the schizophrenics are broken down into early and chronic ones, then abnormally prolonged PINV is present in 94% of early schizophrenics and 44% of chronic schizophrenics, suggesting a trend with time towards normality.

## Psychotherapy bag

One panel discussion that drew much attention posed the question "Is psychotherapy anybody's bag?" Dr. G. J. Sarwer-Foner, Ottawa, argued that tradition, logic and political realities dictate that psychotherapy is a medical act and should be the domain of the psychiatrist. Dr. N. B. Epstein of Hamilton, warning against "trade unionism" in tackling such a question, felt the real issue was in establishing training objectives and means of evaluating the attainment of such rather than focusing on particular disciplinary backgrounds. All panellists seemed to agree that a mental health team was essential, that certainly other disciplines could be taught and were, in fact, doing psychotherapy. But, it was noted, outside the medical profession, standards and the maintenance of such were haphazard and that possibly it was up to the medical profession to not just collaborate but continue to provide leadership.

## Academic lecture

Surprisingly this year there were no papers pertaining to the rapidly developing field of biofeedback. However, more than compensating for that was



**Frank Miller:**  
chronic psychoses need study

the academic lecture for 1974, "Effects of learning on emotions and psychosomatic symptoms", given by Dr. Neal Miller, professor and head of the laboratory of physiological psychology, Rockefeller University, New York. Dr. Miller, generally regarded as a leading learning theorist, was the first to demonstrate that autonomic or visceral reactions could be operantly conditioned. The clinical ramifications of this are immediately obvious: namely, that such autonomic imbalances as hypertension, asthma, cardiac arrhythmias and so on can conceivably be brought under voluntary control without the aid of drugs. Dr. Miller, in reviewing some of the human experiments in this area over the last few years, indicated that there have been some startling results with some individuals; but he cautioned against undue optimism and false promise in that results have often been transient in nature, and it is clear that there is great individual variation in the ability to control visceral functions; "there are autonomic athletes and duffers," he said. The startling fact that one child has been trained to achieve, at will, a temperature differential between two fingers on one hand indicates that the control cannot be attributed to voluntary muscle or placebo factors.

This eminent psychologist also briskly reviewed recent work from his laboratory on stress and helplessness in rats which seems to tie in well with monoamine theories of depression.

In the last few years, there has been an increasing interest in less expensive

# 'Aldomet'

Tablets  
(methyldopa, MSD Ltd.)

**Indications:** Sustained moderate through severe hypertension.

**Dosage Summary:** Start usually with 250 mg two or three times daily during the first 48 hours; thereafter adjust at intervals of not less than two days according to the patient's response. Maximal daily dosage is 3.0 g of methyldopa. In the presence of impaired renal function smaller doses may be needed.

Syncope in older patients has been related to an increased sensitivity in those patients with advanced arteriosclerotic vascular disease and may be avoided by reducing the dose.

Tolerance may occur occasionally between the second and third month after initiating therapy. Effectiveness can frequently be restored by increasing the dose or adding a thiazide.

**Contraindications:** Active hepatic disease such as acute hepatitis and active cirrhosis; known sensitivity to methyldopa; unsuitable in mild or labile hypertension responsive to mild sedation or thiazides alone; pheochromocytoma; pregnancy. Use cautiously if there is a history of liver disease or dysfunction.

**Precautions:** Acquired hemolytic anemia has occurred rarely. Hemoglobin and/or hematocrit determinations should be performed when anemia is suspected. If anemia is present, determine if hemolysis is present. Discontinue methyldopa on evidence of hemolytic anemia. Prompt remission usually results on discontinuation alone or the initiation of adrenocortical steroids. Rarely, however, fatalities have occurred.

A positive direct Coombs test has been reported in some patients on continued therapy with methyldopa, the exact mechanism and significance of which is not established. Incidence has varied from 10 to 20%. If a positive test is to develop it usually does within 12 months following start of therapy. Reversal of positive test occurs within weeks to months after discontinuation of the drug. Prior knowledge of this reaction will aid in cross matching blood for transfusion. This may result in incompatible minor cross match. If the indirect Coombs test is negative, transfusion with otherwise compatible blood may be carried out. If positive, advisability of transfusion should be determined by a hematologist or expert in transfusion problems.

Reversible leukopenia with primary effect on granulocytes has been seen rarely. Rare cases of clinical agranulocytosis have been reported. Granulocyte and leukocyte counts returned promptly to normal on discontinuance of drug.

Occasionally fever has occurred within the first three weeks of therapy, sometimes associated with eosinophilia abnormalities in one or more liver function tests. Jaundice, with or without fever, may occur also, with onset usually within first 2 or 3 months of therapy. Rare cases of fatal hepatic necrosis have been reported. Liver biopsies in several patients with liver dysfunction showed a microscopic focal necrosis compatible with drug hypersensitivity. Determine liver function, leukocyte and differential blood counts at intervals during the first six to eight weeks of therapy or whenever unexplained fever may occur. Discontinue if fever, abnormalities in liver function tests, or jaundice occur.

Methyldopa may potentiate action of other antihypertensive drugs. Follow patients carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Patients may require reduced doses of anesthetics when on "ALDOMET". If hypotension does occur during anesthesia, it usually can be controlled by vasopressors. The adrenergic receptors remain sensitive during treatment with methyldopa.

Hypertension occasionally noted after dialysis in patients treated with "ALDOMET" may occur because the drug is removed by this procedure.

Rarely involuntary choreoathetotic movements have been observed during therapy with methyldopa in patients with severe bilateral cerebrovascular disease. Should these movements occur, discontinue therapy.

Fluorescence in urine samples at same wave lengths as catecholamines may be reported as urinary catecholamines. This will interfere with the diagnosis of pheochromocytoma. Methyldopa will not serve as a diagnostic test for pheochromocytoma.

**Usage in Pregnancy:** Because clinical experience and follow-up studies in pregnancy have been limited, the use of methyldopa when pregnancy is present or suspected requires that the benefits of the drug be weighed against the possible hazards to the fetus.

**Adverse Reactions:** Cardiovascular: Angina pectoris may be aggravated; reduce dosage if symptoms of orthostatic hypotension occur; bradycardia occurs occasionally. Neurological: Symptoms associated with effective lowering of blood pressure occasionally seen include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Sedation, usually transient, seen during initial therapy or when dose is increased. Similarly, headache, asthenia, or weakness may be noted as early, but transient symptoms. Rarely reported: paresthesias, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression, and a single case of bilateral Bell's palsy. Gastrointestinal: Occasional reactions generally relieved by decrease in dosage: mild dryness of the mouth and gastrointestinal symptoms including distention, constipation, flatulence, and diarrhea; rarely, nausea and vomiting. Pancreatitis and inflammation of the salivary glands may occur during therapy. Hematological: Positive direct Coombs test, acquired hemolytic anemia, leukopenia and rare cases of thrombocytopenia. Toxic and Allergic: Occasional drug related fever and abnormal liver function studies with jaundice and hepatocellular damage, (see PRECAUTIONS) and a rise in BUN. Rarely, skin rash, sore tongue or "black tongue". Endocrine and Metabolic: Rarely, breast enlargement, lactation, impotence, decreased libido, weight gain and edema which may be relieved by administering a thiazide diuretic. If edema progresses or signs of pulmonary congestion appear, discontinue drug. Miscellaneous: Occasionally nasal stuffiness, mild arthralgia and myalgia; rarely, darkening of urine after voiding.

Full information on dosage, contraindications, precautions, adverse reactions and references is available on request.

**How Supplied:** Film Coated Tablets "ALDOMET" are yellow, film-coated, biconvex-shaped tablets, with the MSD symbol engraved on one side, and are supplied as follows:

Ca 8737—each tablet containing 125 mg of methyldopa, supplied in bottles of 100 and 500 tablets.

Ca 3290—each tablet containing 250 mg of methyldopa, supplied in bottles of 50 and 500 tablets.

Ca 8733—each tablet containing 500 mg of methyldopa, supplied in bottles of 50 and 250 tablets.

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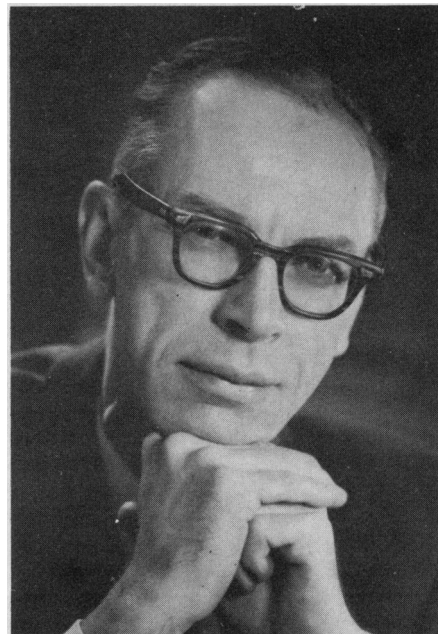
and more efficient alternatives to traditional hospital care. A number of groups in Canada seem to be looking at this question. G. Reith, Ph.D. *et al* (Vancouver) compared on numerous parameters inpatient treatment of neurotics with a day-care facility and a therapeutic community set in a rustic forest lodge 40 miles outside Vancouver. A one- and two-year follow-up revealed not only that 80% of non-suicidal, neurotic patients can be treated outside an expensive hospital setting but that the therapeutic-community approach tends to be more effective, more lasting, results in fewer readmissions and is only 18% of the inpatient cost of \$74 a day.

Preliminary results from Dr. F. R. Fenton, Montreal, showed that symptoms of depression, anxiety, social isolation and belligerent and negativistic behaviour are significantly ameliorated in both randomly assigned home care and hospital groups during the first four weeks of treatment. However, it was also noted that over a four-week period symptoms affecting reality testing disturbance and impulse control problems appear to be ameliorated in the hospital care group but *not* in the home care group.

An obvious money-saving program was that of Dr. George Voineskos who described a self-care unit at the Queen Street Mental Health Centre in Toronto where for more than a year patients have been without nursing supervision of any kind in the evenings and weekends. The patients are selected for such a program and it has been found to be particularly beneficial for patients for whom independence and self-sufficiency are a particular aim.

## Physician as patient

One descriptive paper that obviously had a captive audience was that of Krell and Miles (Toronto) who drew certain conclusions after doing marital therapy with 10 couples where the male partner was a physician. Ironically physicians have difficulty channelling themselves to appropriate care. The authors point out that request for help is usually almost too late or precipitated by a request for psychiatric evaluation of a child or hospitalization of the physician's wife. Not too surprisingly, seven of the 10 wives were registered nurses. Self-diagnosis and self-medication and the professional stance of a nurse-physician team can often interfere with the working through of husband-wife conflicts. For this and other reasons, the authors suggest that conjoint marital therapy is more likely to succeed than individual therapy. Lifestyles of these physician families were often found to be chaotic, revolving around work which in itself was often used as an



**Chalke: emphasize scientific method**

escape from family responsibilities.

Dr. Rhodes Chalke, Ottawa, retiring president, in his formal address called for greater emphasis on the scientific method in psychiatry. Analysing the interplay between the arts and sciences (and leaning somewhat on works by a non-physician, C. P. Snow, and a non-scientist, journalist Arthur Koestler) he urged "lining up" to the strict criteria of biological science as far as applicable. He described the application of the scientific method to psychiatric problems as showing "a degree of shoddiness that should be unacceptable in medicine in general".

The Clarke Institute research award for the past year was shared by Dr. C. D. Webster for his paper, "Some correlates of marijuana, self-administered in man: A study of titration of intake as a function of drug potency" and Drs. D. Coscina and H. C. Stancer for their paper, "Consumatory behaviours of hypothalamic, hyperphagic rats after a central injection of 6-hydroxydopamine". The McNeil award given to the authors of the best paper presented at last year's meeting went to Drs. H. E. Lehman and T. A. Ban for their work on the use of nicotinic acid in the treatment of schizophrenics.

Dr. Colin M. Smith was invested president for 1974-75. Dr. Smith, a graduate of Glasgow and Saskatchewan, is clinical professor of psychiatry, University of Saskatchewan and Saskatchewan director of psychiatric services. The new president-elect is Dr. J. B. Boulanger of Montreal. Other members elected (or, more accurately, re-elected) to the executive were: chairman of the board, Dr. J. S. Pratten; treasurer, Dr. D. R. Pushman; secretary, Dr. A. J. Cote. ■